Senate Bill No. 227

CHAPTER 31

An act to amend Sections 1389.25 and 1389.4 of the Health and Safety Code, and to amend Sections 10113.9 and 10113.95 of, to add Section 12739.755 to, and to add and repeal Part 6.6 (commencing with Section 12739.5) of Division 2 of, the Insurance Code, relating to health care coverage, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor June 29, 2010. Filed with Secretary of State June 29, 2010.]

LEGISLATIVE COUNSEL'S DIGEST

SB 227, Alquist. Health care coverage: temporary high risk pool.

Existing law, the federal Patient Protection and Affordable Care Act, requires the United States Secretary of Health and Human Services to establish a temporary high risk health insurance pool program to provide health insurance coverage for eligible individuals until January 1, 2014. Existing law authorizes the secretary to implement this program directly or through contracts with eligible entities, including the states, and requires that federal money made available pursuant to these provisions be used to establish a qualified high risk pool that meets certain requirements.

Existing law establishes the California Major Risk Medical Insurance Program, which is administered by the Managed Risk Medical Insurance Board (MRMIB), to provide major risk medical coverage to persons who, among other things, have been rejected for coverage by at least one private health plan.

This bill would require MRMIB to enter into an agreement with the federal Department of Health and Human Services to administer a temporary high risk pool to provide health coverage, until January 1, 2014, to specified individuals who have preexisting conditions, consistent with the federal Patient Protection and Affordable Care Act. The bill would repeal these provisions on January 1, 2020. The bill would also appropriate $761,000,000 from the Federal Trust Fund to MRMIB for the purposes of these provisions.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or a health insurer that rejects an applicant for individual coverage or offers individual coverage at a rate higher than the standard rate to inform the applicant about the California Major Risk Medical Insurance Program.

This bill would also require the plan or insurer to inform the applicant about the temporary high risk pool established pursuant to the bill and would require that information to be provided in accordance with standards developed by the Department of Managed Health Care or the Department of Insurance, as specified. Because a willful violation of this requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program. The bill would also require the Department of Managed Health Care and the Department of Insurance to post information on their Internet Web sites about the temporary high risk pool established pursuant to the bill.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

This bill would provide that it shall become operative only if AB 1887 of the 2009–10 Regular Session is also enacted and becomes operative.

This bill would declare that it is to take effect immediately as an urgency statute.

Appropriation: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1389.25 of the Health and Safety Code is amended to read:

1389.25. (a) (1) This section shall apply only to a full service health care service plan offering health coverage in the individual market in California and shall not apply to a specialized health care service plan, a health care service plan contract in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), a health care service plan conversion contract offered pursuant to Section 1373.6, a health care service plan contract in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), or a health care service plan contract offered to a federally eligible defined individual under Article 4.6 (commencing with Section 1366.35).

(2) A local initiative, as defined in subdivision (v) of Section 53810 of Title 22 of the California Code of Regulations, that is awarded a contract by the State Department of Health Care Services pursuant to subdivision (b) of Section 53800 of Title 22 of the California Code of Regulations, shall not be subject to this section unless the plan offers coverage in the individual market to persons not covered by Medi-Cal or the Healthy Families Program.

(b) (1) A health care service plan that declines to offer coverage or denies enrollment for an individual or his or her dependents applying for individual coverage or that offers individual coverage at a rate that is higher than the standard rate, shall provide the individual applicant with the specific reason

or reasons for the decision in writing at the time of the denial or offer of coverage.

(2) No change in the premium rate or coverage for an individual plan contract shall become effective unless the plan has delivered a written notice of the change at least 30 days prior to the effective date of the contract renewal or the date on which the rate or coverage changes. A notice of an increase in the premium rate shall include the reasons for the rate increase.

(3) The written notice required pursuant to paragraph (2) shall be delivered to the individual contractholder at his or her last address known to the plan, at least 30 days prior to the effective date of the change. The notice shall state in italics either the actual dollar amount of the premium rate increase or the specific percentage by which the current premium will be increased. The notice shall describe in plain, understandable English any changes in the plan design or any changes in benefits, including a reduction in benefits or changes to waivers, exclusions, or conditions, and highlight this information by printing it in italics. The notice shall specify in a minimum of 10-point bold typeface, the reason for a premium rate change or a change to the plan design or benefits.

(4) If a plan rejects an applicant or the dependents of an applicant for coverage or offers individual coverage at a rate that is higher than the standard rate, the plan shall inform the applicant about the state's high-risk health insurance pool, the California Major Risk Medical Insurance Program (MRMIP) (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code), and the federal temporary high risk pool established pursuant to Part 6.6 (commencing with Section 12739.5) of Division 2 of the Insurance Code. The information provided to the applicant by the plan shall be in accordance with standards developed by the department, in consultation with the Managed Risk Medical Insurance Board, and shall specifically include the toll-free telephone number and Internet Web site address for MRMIP and the federal temporary high risk pool. The requirement to notify applicants of the availability of MRMIP and the federal temporary high risk pool shall not apply when a health plan rejects an applicant for Medicare supplement coverage.

(c) A notice provided pursuant to this section is a private and confidential communication and, at the time of application, the plan shall give the individual applicant the opportunity to designate the address for receipt of the written notice in order to protect the confidentiality of any personal or privileged information.

SEC. 2. Section 1389.4 of the Health and Safety Code is amended to read:

1389.4. (a) A full service health care service plan that issues, renews, or amends individual health plan contracts shall be subject to this section.

(b) A health care service plan subject to this section shall have written policies, procedures, or underwriting guidelines establishing the criteria and process whereby the plan makes its decision to provide or to deny coverage to individuals applying for coverage and sets the rate for that coverage. These guidelines, policies, or procedures shall assure that the plan rating

and underwriting criteria comply with Sections 1365.5 and 1389.1 and all other applicable provisions of state and federal law.

(c) On or before June 1, 2006, and annually thereafter, every health care service plan shall file with the department a general description of the criteria, policies, procedures, or guidelines the plan uses for rating and underwriting decisions related to individual health plan contracts, which means automatic declinable health conditions, health conditions that may lead to a coverage decline, height and weight standards, health history, health care utilization, lifestyle, or behavior that might result in a decline for coverage or severely limit the plan products for which they would be eligible. A plan may comply with this section by submitting to the department underwriting materials or resource guides provided to plan solicitors or solicitor firms, provided that those materials include the information required to be submitted by this section.

(d) Commencing January 1, 2011, the director shall post on the department's Internet Web site, in a manner accessible and understandable to consumers, general, noncompany specific information about rating and underwriting criteria and practices in the individual market and information about the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code) and the federal temporary high risk pool established pursuant to Part 6.6 (commencing with Section 12739.5) of Division 2 of the Insurance Code. The director shall develop the information for the Internet Web site in consultation with the Department of Insurance to enhance the consistency of information provided to consumers. Information about individual health coverage shall also include the following notification:

"Please examine your options carefully before declining group coverage or continuation coverage, such as COBRA, that may be available to you. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."

(e) Nothing in this section shall authorize public disclosure of company specific rating and underwriting criteria and practices submitted to the director.

(f) This section shall not apply to a closed block of business, as defined in Section 1367.15.

SEC. 3. Section 10113.9 of the Insurance Code is amended to read:

10113.9. (a) This section shall not apply to short-term limited duration health insurance, vision-only, dental-only, or CHAMPUS-supplement insurance, or to hospital indemnity, hospital-only, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.

(b) No change in the premium rate or coverage for an individual health insurance policy shall become effective unless the insurer has delivered a written notice of the change at least 30 days prior to the effective date of the policy renewal or the date on which the rate or coverage changes. A

notice of an increase in the premium rate shall include the reasons for the rate increase.

(c) The written notice required pursuant to subdivision (b) shall be delivered to the individual policyholder at his or her last address known to the insurer, at least 30 days prior to the effective date of the change. The notice shall state in italics either the actual dollar amount of the premium increase or the specific percentage by which the current premium will be increased. The notice shall describe in plain, understandable English any changes in the policy or any changes in benefits, including a reduction in benefits or changes to waivers, exclusions, or conditions, and highlight this information by printing it in italics. The notice shall specify in a minimum of 10-point bold typeface, the reason for a premium rate change or a change in coverage or benefits.

(d) If an insurer rejects an applicant or the dependents of an applicant for coverage or offers individual coverage at a rate that is higher than the standard rate, the insurer shall inform the applicant about the state's high-risk health insurance pool, the California Major Risk Medical Insurance Program (MRMIP) (Part 6.5 (commencing with Section 12700)), and the federal temporary high risk pool established pursuant to Part 6.6 (commencing with Section 12739.5). The information provided to the applicant by the insurer shall be in accordance with standards developed by the department, in consultation with the Managed Risk Medical Insurance Board, and shall specifically include the toll-free telephone number and Internet Web site address for MRMIP and the federal temporary high risk pool. The requirement to notify applicants of the availability of MRMIP and the federal temporary high risk pool shall not apply when a health plan rejects an applicant for Medicare supplement coverage.

SEC. 4. Section 10113.95 of the Insurance Code is amended to read:

10113.95. (a) A health insurer that issues, renews, or amends individual health insurance policies shall be subject to this section.

(b) An insurer subject to this section shall have written policies, procedures, or underwriting guidelines establishing the criteria and process whereby the insurer makes its decision to provide or to deny coverage to individuals applying for coverage and sets the rate for that coverage. These guidelines, policies, or procedures shall assure that the plan rating and underwriting criteria comply with Sections 10140 and 10291.5 and all other applicable provisions.

(c) On or before June 1, 2006, and annually thereafter, every insurer shall file with the commissioner a general description of the criteria, policies, procedures, or guidelines that the insurer uses for rating and underwriting decisions related to individual health insurance policies, which means automatic declinable health conditions, health conditions that may lead to a coverage decline, height and weight standards, health history, health care utilization, lifestyle, or behavior that might result in a decline for coverage or severely limit the health insurance products for which they would be eligible. An insurer may comply with this section by submitting to the department underwriting materials or resource guides provided to agents

and brokers, provided that those materials include the information required to be submitted by this section.

(d) Commencing January 1, 2011, the commissioner shall post on the department's Internet Web site, in a manner accessible and understandable to consumers, general, noncompany specific information about rating and underwriting criteria and practices in the individual market and information about the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700) and the federal temporary high risk pool established pursuant to Part 6.6 (commencing with Section 12739.5) of Division 2. The commissioner shall develop the information for the Internet Web site in consultation with the Department of Managed Health Care to enhance the consistency of information provided to consumers. Information about individual health insurance shall also include the following notification:

"Please examine your options carefully before declining group coverage or continuation coverage, such as COBRA, that may be available to you. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."

(e) Nothing in this section shall authorize public disclosure of company-specific rating and underwriting criteria and practices submitted to the commissioner.

(f) This section shall not apply to a closed block of business, as defined in Section 10176.10.

SEC. 5. Part 6.6 (commencing with Section 12739.5) is added to Division 2 of the Insurance Code, to read:

PART 6.6. QUALIFIED HIGH RISK POOLS

12739.5. It is the intent of the Legislature to implement Section 1101 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) in California to establish a temporary high risk pool so that access to health coverage for individuals with preexisting medical conditions can be effectively and promptly provided by the Managed Risk Medical Insurance Board.

12739.50. For the purposes of this part, the following terms have the following meanings:

(a) "Applicant" means an individual who applies for high risk medical coverage through the program.

(b) "Board" means the Managed Risk Medical Insurance Board.

(c) "Federal temporary high risk pool" is the temporary high risk health insurance pool program established pursuant to Section 1101 of the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(d) "Fund" means the Federal Temporary High Risk Health Insurance Fund, established in Section 12739.71, from which the board may authorize expenditures to pay for all of the following:

(1) Covered, medically necessary services that exceed subscribers' contributions.

(2) Administration of the program.

(3) Marketing and outreach.

(e) "High risk medical coverage" or "coverage" means payment for medically necessary services provided by institutional and professional providers through the program.

(f) "Participating health plan" means a private insurer holding a valid outstanding certificate of authority from the Insurance Commissioner or a health care service plan, as defined under subdivision (f) of Section 1345 of the Health and Safety Code, that contracts with the program to provide or administer high risk medical coverage to program subscribers.

(g) "Plan rates" means the total monthly amount charged by a participating health plan to provide or administer high risk medical coverage.

(h) "Program" means the Federal Temporary High Risk Pool through which the board operates the federal temporary high risk pool in California.

(i) "Subscriber" means an eligible individual, as defined in subsection (d) of Section 1101 of the federal Patient Protection and Affordable Care Act (Public Law 111-148), who is enrolled in the program, and includes a member of a federally recognized California Indian tribe.

(j) "Subscriber contribution" means the premium for high risk medical coverage paid by the subscriber or, if authorized by the federal government, paid on behalf of the subscriber by a federally recognized California Indian tribal government. If a federally recognized California Indian tribal government makes a contribution on behalf of a member of the tribe, the tribal government shall ensure that the subscriber is made aware of all the health coverage options, including participating health plans, available in the county where the member resides.

12739.51. The Federal Temporary High Risk Pool is hereby created in the California Health and Human Services Agency. The program shall be managed by the board.

12739.52. The board shall have the authority to do all of the following, consistent with Section 1101 of the federal Patient Protection and Affordable Care Act (Public Law 111-148):

(a) Enter into an agreement with the federal Department of Health and Human Services to administer the federal temporary high risk pool as provided in Section 12739.53.

(b) Determine eligibility criteria and enrollment and disenrollment criteria and processes, including processes for waiting lists, enrollment limits, disenrollments, and any other limits on enrollment needed to maintain program expenditures within available federal funds.

(c) Determine the participation requirements of applicants, subscribers, and participating health plans, third-party administrators, and other contractors.

(d) Determine when subscribers' coverage begins and ends.

(e) Provide for the processing of applications and the enrollment of subscribers.

(f) Determine the high risk medical coverage to be provided to subscribers, including the scope of benefits and subscriber cost sharing.

(g) Establish subscriber contributions and plan rates.

(h) (1) Provide high risk medical coverage for subscribers through contracts with participating health plans or third-party administrators to provide or administer the coverage. A contract between the board and a participating health plan may provide that the contracting health plan assumes full or partial risk for the cost of covered health services or that the contracting health plan undertakes to provide only administrative services for the state's self-insured high risk medical coverage. A contract between the board and a third-party administrator may provide that the third-party administrator undertakes to provide only administrative services for the state's self-insured high risk medical coverage. The board may provide or purchase stop-loss coverage under which the program and participating health plans or stop-loss insurers share the risk for health plan expenses that exceed plan rates.

(2) Nothing in paragraph (1) shall be construed to alter the rights of a participating health plan under existing law if the board is unable to continue payment to the plan in accordance with the terms of the plan's contract with the board.

(i) Authorize expenditures from the fund to pay program expenses that exceed subscriber contributions.

(j) Contract for administration of the program or any portion of the program with any public agency, including any agency of state government, or with any private entity.

(k) If, and to the extent, permitted by federal law and by the federal Department of Health and Human Services, align program administration with the administration of the Major Risk Medical Insurance Program established pursuant to Part 6.5 (commencing with Section 12700) to ensure coordination and administrative efficiency.

(*l*) Sue and be sued.

(m) Employ necessary staff.

(n) Refer potential violations of state and federal law by participating health plans and other entities and persons to the appropriate regulatory agencies.

(o) Subject to the approval of the Department of Finance, obtain loans from the General Fund for all necessary and reasonable expenses related to the administration of the fund and the program. The board shall repay principal and interest, using the pooled money investment account rate of interest, to the General Fund no later than July 1, 2014.

(p) (1) Issue rules and regulations to carry out the purposes of this part. The adoption and readoption of regulations to implement this part shall be deemed to be an emergency that calls for immediate action to avoid serious harm to the public peace, health, safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted from the requirement that the board describe facts showing

the need for immediate action and from review by the Office of Administrative Law.

(2) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the board shall, without taking any regulatory action, initially implement this section pursuant to the agreement with the federal Department of Health and Human Services described in subdivision (a) of Section 12739.53. Thereafter, the board shall adopt any necessary regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code and with paragraph (1) of this subdivision.

(q) Exercise all powers reasonably necessary to carry out the powers and responsibilities expressly granted or imposed upon the board under this part, including the powers and responsibilities necessary to enter into an agreement with, and comply with the requirements of, the federal Department of Health and Human Services as described in subdivision (a) of Section 12739.53.

12739.53. (a) The board shall, consistent with Section 1101 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) and State and federal law and contingent on the agreement of the federal Department of Health and Human Services and receipt of sufficient federal funding, enter into an agreement with the federal Department of Health and Human Services to administer the federal temporary high risk pool in California.

(b) If the federal Department of Health and Human Services and the state enter into an agreement to administer the federal temporary high risk pool, the board shall do all of the following:

(1) Administer the program pursuant to that agreement.

(2) Begin providing coverage in the program on the date established pursuant to the agreement with the federal Department of Health and Human Services.

(3) Establish the scope and content of high risk medical coverage.

(4) Determine reasonable minimum standards for participating health plans, third-party administrators, and other contractors.

(5) Determine the time, manner, method, and procedures for withdrawing program approval from a plan, third-party administrator, or other contractor, or limiting enrollment of subscribers in a plan.

(6) Research and assess the needs of persons without adequate health coverage and promote means of ensuring the availability of adequate health care services.

(7) Administer the program to ensure the following:

(A) That the program subsidy amount does not exceed amounts transferred to the fund pursuant to this part.

(B) That the aggregate amount spent for high risk medical coverage and program administration does not exceed the federal funds available to the state for this purpose and that no state funds are spent for the purposes of this part.

(8) Maintain enrollment and expenditures to ensure that expenditures do not exceed amounts available in the fund and that no state funds are spent for purposes of this part. If sufficient funds are not available to cover the estimated cost of program expenditures, the board shall institute appropriate measures to limit enrollment.

(9) In adopting benefit and eligibility standards, be guided by the needs and welfare of persons unable to secure adequate health coverage for themselves and their dependents and by prevailing practices among private health plans.

(10) As required by the federal Department of Health and Human Services, implement procedures to provide for the transition of subscribers into qualified health plans offered through an exchange or exchanges to be established pursuant to the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(11) Post on the board's Internet Web site the monthly progress reports submitted to the federal Department of Health and Human Services. In addition, the board shall provide notice of any anticipated waiting lists or disenrollments due to insufficient funding to the public, by making that notice available as part of its board meetings, and concurrently to the Legislature.

(12) Develop and implement a plan for marketing and outreach.

(c) There shall not be any liability in a private capacity on the part of the board or any member of the board, or any officer or employee of the board for or on account of any act performed or obligation entered into in an official capacity, when done in good faith, without intent to defraud, and in connection with the administration, management, or conduct of this part or affairs related to this part.

12739.54. (a) Plan rates for high risk medical benefits approved for the program shall not be excessive, inadequate, or unfairly discriminatory, but shall be adequate to pay anticipated costs of claims or services and administration.

(b) As a condition of reimbursement, participating health plans or third-party administrators shall submit claims to the board within 18 months following the date of service. The board may vary the time limit established in this subdivision if necessary to administer the reimbursement or reconciliation processes established by the board or to meet the requirements of the state's agreement with the federal Department of Health and Human Services described in subdivision (a) of Section 12739.53.

12739.55. The program may place a lien on compensation or benefits recovered or recoverable by a subscriber from any party or parties responsible for the compensation or benefits for which benefits have been provided pursuant to this part.

12739.56. Except as provided in Article 3.5 (commencing with Section 14124.70) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, benefits received under this part are in excess of, and secondary to, any other form of health benefits coverage.

12739.57. The board shall provide coverage pursuant to this part through participating health plans or through provider networks using a third-party administrator and may contract for the processing of applications, the enrollment of subscribers, and all activities necessary to administer the program. Any contract entered into pursuant to this part shall be exempt from any provision of law relating to competitive bidding, and shall be exempt from the review or approval of any division of the Department of General Services. The board shall not be required to specify the amounts encumbered for each contract but may allocate funds to each contract based on projected and actual subscriber enrollments in a total amount not to exceed revenue available for the program.

12739.58. A transfer of enrollment from one participating health plan to another may be made by a subscriber at times and under conditions as may be prescribed by regulations of the program.

12739.59. (a) Program decisions concerning an applicant's or subscriber's eligibility or eligibility date may be appealed to the board, according to procedures to be established by the board.

(b) Coverage determinations may be appealed to the board, according to procedures established by the board. If permitted by the federal Department of Health and Human Services, the board shall not be required to provide an appeal concerning a coverage determination if the subject of the appeal is within the jurisdiction of the Department of Managed Health Care pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) and its implementing regulations or within the jurisdiction of the Department of Insurance pursuant to the Insurance Code and its implementing regulations.

(c) Hearings shall be conducted according to the requirements of the federal Department of Health and Human Services and, insofar as practicable and not inconsistent with those requirements, pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

12739.60. Upon enrollment as a subscriber in the program, the subscriber shall be responsible for payment of the subscriber contribution.

12739.61. The board shall cease to provide coverage through the program on January 1, 2014, and at that time shall cease to operate the program except as required to complete payments to, or payment reconciliations with, participating health plans or other contractors, process appeals, or conduct other necessary transition activities, including, but not limited to, transition of subscribers into an exchange or exchanges established pursuant to the federal Patient Protection and Affordable Care Act (Public Law 111-148).

12739.62. This part shall remain in effect only until January 1, 2020, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2020, deletes or extends that date.

SEC. 6. Section 12739.755 is added to the Insurance Code, to read:

12739.755. The sum of seven hundred sixty-one million dollars ($761,000,000) is hereby appropriated without regard to fiscal years from the Federal Trust Fund to the board, from funds received from the federal government under Section 1101 of the federal Patient Protection and Affordable Care Act (Public Law 111-148), for transfer to the fund for the purposes specified in Section 12739.71.

SEC. 7. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

SEC. 8. This act shall become operative only if Assembly Bill 1887 of the 2009–10 Regular Session is also enacted and becomes operative.

SEC. 9. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to allow the state to apply for federal funding made available by Section 1101 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) at the earliest possible time, it is necessary that this act take effect immediately.

O

Assembly Bill No. 1887

CHAPTER 32

An act to amend Sections 6254 and 11126 of the Government Code, and to add and repeal Part 6.7 (commencing with Section 12739.70) of Division 2 of the Insurance Code, relating to health care coverage, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor June 29, 2010. Filed with Secretary of State June 29, 2010.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1887, Villines. Temporary high risk pool.

Existing law, the federal Patient Protection and Affordable Care Act, requires the United States Secretary of Health and Human Services to establish a temporary high risk health insurance pool program to provide health insurance coverage for eligible individuals until January 1, 2014. Existing law authorizes the secretary to carry out this program directly or through contracts to eligible entities, including states, and requires that money made available pursuant to these provisions be used to establish a qualified high risk pool that meets certain requirements.

Existing law establishes the California Major Risk Medical Insurance Program, which is administered by the Managed Risk Medical Insurance Board (MRMIB), to provide major risk medical coverage to persons who, among other matters, have been rejected for coverage by at least one private health plan.

This bill would establish the Federal Temporary High Risk Health Insurance Fund as a continuously appropriated fund to administer the qualified high risk pool required by federal law, thereby making an appropriation. The bill would repeal these provisions on January 1, 2020.

Existing law exempts from the Public Records Act records of MRMIB related to contract negotiations and deliberations, and exempts from the Bagley-Keene Open Meeting Act matters related to the development of rates and contracting strategy for entities contracting or seeking to contract with MRMIB.

This bill would add to those exemptions records and meetings of MRMIB with regard to contract negotiations with entities with which MRMIB is considering or enters into any arrangement under which MRMIB provides, receives, or arranges services or reimbursement, including those negotiations conducted for purposes of the qualified high risk pool and the fund created by the bill.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public

officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

This bill would provide that it shall become operative only if SB 227 of the 2009–10 Regular Session is also enacted and becomes operative.

The bill would declare that it is to take effect immediately as an urgency statute.

Appropriation: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 6254 of the Government Code is amended to read:

6254. Except as provided in Sections 6254.7 and 6254.13, nothing in this chapter shall be construed to require disclosure of records that are any of the following:

(a) Preliminary drafts, notes, or interagency or intra-agency memoranda that are not retained by the public agency in the ordinary course of business, if the public interest in withholding those records clearly outweighs the public interest in disclosure.

(b) Records pertaining to pending litigation to which the public agency is a party, or to claims made pursuant to Division 3.6 (commencing with Section 810), until the pending litigation or claim has been finally adjudicated or otherwise settled.

(c) Personnel, medical, or similar files, the disclosure of which would constitute an unwarranted invasion of personal privacy.

(d) Contained in or related to any of the following:

(1) Applications filed with any state agency responsible for the regulation or supervision of the issuance of securities or of financial institutions, including, but not limited to, banks, savings and loan associations, industrial loan companies, credit unions, and insurance companies.

(2) Examination, operating, or condition reports prepared by, on behalf of, or for the use of, any state agency referred to in paragraph (1).

(3) Preliminary drafts, notes, or interagency or intra-agency communications prepared by, on behalf of, or for the use of, any state agency referred to in paragraph (1).

(4) Information received in confidence by any state agency referred to in paragraph (1).

(e) Geological and geophysical data, plant production data, and similar information relating to utility systems development, or market or crop reports, that are obtained in confidence from any person.

(f) Records of complaints to, or investigations conducted by, or records of intelligence information or security procedures of, the office of the Attorney General and the Department of Justice, the California Emergency Management Agency, and any state or local police agency, or any investigatory or security files compiled by any other state or local police agency, or any investigatory or security files compiled by any other state

or local agency for correctional, law enforcement, or licensing purposes. However, state and local law enforcement agencies shall disclose the names and addresses of persons involved in, or witnesses other than confidential informants to, the incident, the description of any property involved, the date, time, and location of the incident, all diagrams, statements of the parties involved in the incident, the statements of all witnesses, other than confidential informants, to the victims of an incident, or an authorized representative thereof, an insurance carrier against which a claim has been or might be made, and any person suffering bodily injury or property damage or loss, as the result of the incident caused by arson, burglary, fire, explosion, larceny, robbery, carjacking, vandalism, vehicle theft, or a crime as defined by subdivision (b) of Section 13951, unless the disclosure would endanger the safety of a witness or other person involved in the investigation, or unless disclosure would endanger the successful completion of the investigation or a related investigation. However, nothing in this division shall require the disclosure of that portion of those investigative files that reflects the analysis or conclusions of the investigating officer.

Customer lists provided to a state or local police agency by an alarm or security company at the request of the agency shall be construed to be records subject to this subdivision.

Notwithstanding any other provision of this subdivision, state and local law enforcement agencies shall make public the following information, except to the extent that disclosure of a particular item of information would endanger the safety of a person involved in an investigation or would endanger the successful completion of the investigation or a related investigation:

(1) The full name and occupation of every individual arrested by the agency, the individual's physical description including date of birth, color of eyes and hair, sex, height and weight, the time and date of arrest, the time and date of booking, the location of the arrest, the factual circumstances surrounding the arrest, the amount of bail set, the time and manner of release or the location where the individual is currently being held, and all charges the individual is being held upon, including any outstanding warrants from other jurisdictions and parole or probation holds.

(2) Subject to the restrictions imposed by Section 841.5 of the Penal Code, the time, substance, and location of all complaints or requests for assistance received by the agency and the time and nature of the response thereto, including, to the extent the information regarding crimes alleged or committed or any other incident investigated is recorded, the time, date, and location of occurrence, the time and date of the report, the name and age of the victim, the factual circumstances surrounding the crime or incident, and a general description of any injuries, property, or weapons involved. The name of a victim of any crime defined by Section 220, 236.1, 261, 261.5, 262, 264, 264.1, 265, 266, 266a, 266b, 266c, 266e, 266f, 266j, 267, 269, 273a, 273d, 273.5, 285, 286, 288, 288a, 288.2, 288.3 (as added by Chapter 337 of the Statutes of 2006), 288.3 (as added by Section 6 of Proposition 83 of the November 7, 2006, statewide general election), 288.5,

288.7, 289, 422.6, 422.7, 422.75, 646.9, or 647.6 of the Penal Code may be withheld at the victim's request, or at the request of the victim's parent or guardian if the victim is a minor. When a person is the victim of more than one crime, information disclosing that the person is a victim of a crime defined in any of the sections of the Penal Code set forth in this subdivision may be deleted at the request of the victim, or the victim's parent or guardian if the victim is a minor, in making the report of the crime, or of any crime or incident accompanying the crime, available to the public in compliance with the requirements of this paragraph.

(3) Subject to the restrictions of Section 841.5 of the Penal Code and this subdivision, the current address of every individual arrested by the agency and the current address of the victim of a crime, where the requester declares under penalty of perjury that the request is made for a scholarly, journalistic, political, or governmental purpose, or that the request is made for investigation purposes by a licensed private investigator as described in Chapter 11.3 (commencing with Section 7512) of Division 3 of the Business and Professions Code. However, the address of the victim of any crime defined by Section 220, 236.1, 261, 261.5, 262, 264, 264.1, 265, 266, 266a, 266b, 266c, 266e, 266f, 266j, 267, 269, 273a, 273d, 273.5, 285, 286, 288, 288a, 288.2, 288.3 (as added by Chapter 337 of the Statutes of 2006), 288.3 (as added by Section 6 of Proposition 83 of the November 7, 2006, statewide general election), 288.5, 288.7, 289, 422.6, 422.7, 422.75, 646.9, or 647.6 of the Penal Code shall remain confidential. Address information obtained pursuant to this paragraph may not be used directly or indirectly, or furnished to another, to sell a product or service to any individual or group of individuals, and the requester shall execute a declaration to that effect under penalty of perjury. Nothing in this paragraph shall be construed to prohibit or limit a scholarly, journalistic, political, or government use of address information obtained pursuant to this paragraph.

(g) Test questions, scoring keys, and other examination data used to administer a licensing examination, examination for employment, or academic examination, except as provided for in Chapter 3 (commencing with Section 99150) of Part 65 of Division 14 of Title 3 of the Education Code.

(h) The contents of real estate appraisals or engineering or feasibility estimates and evaluations made for or by the state or local agency relative to the acquisition of property, or to prospective public supply and construction contracts, until all of the property has been acquired or all of the contract agreement obtained. However, the law of eminent domain shall not be affected by this provision.

(i) Information required from any taxpayer in connection with the collection of local taxes that is received in confidence and the disclosure of the information to other persons would result in unfair competitive disadvantage to the person supplying the information.

(j) Library circulation records kept for the purpose of identifying the borrower of items available in libraries, and library and museum materials made or acquired and presented solely for reference or exhibition purposes.

The exemption in this subdivision shall not apply to records of fines imposed on the borrowers.

(k) Records, the disclosure of which is exempted or prohibited pursuant to federal or state law, including, but not limited to, provisions of the Evidence Code relating to privilege.

(*l*) Correspondence of and to the Governor or employees of the Governor's office or in the custody of or maintained by the Governor's Legal Affairs Secretary. However, public records shall not be transferred to the custody of the Governor's Legal Affairs Secretary to evade the disclosure provisions of this chapter.

(m) In the custody of or maintained by the Legislative Counsel, except those records in the public database maintained by the Legislative Counsel that are described in Section 10248.

(n) Statements of personal worth or personal financial data required by a licensing agency and filed by an applicant with the licensing agency to establish his or her personal qualification for the license, certificate, or permit applied for.

(o) Financial data contained in applications for financing under Division 27 (commencing with Section 44500) of the Health and Safety Code, where an authorized officer of the California Pollution Control Financing Authority determines that disclosure of the financial data would be competitively injurious to the applicant and the data is required in order to obtain guarantees from the United States Small Business Administration. The California Pollution Control Financing Authority shall adopt rules for review of individual requests for confidentiality under this section and for making available to the public those portions of an application that are subject to disclosure under this chapter.

(p) Records of state agencies related to activities governed by Chapter 10.3 (commencing with Section 3512), Chapter 10.5 (commencing with Section 3525), and Chapter 12 (commencing with Section 3560) of Division 4, that reveal a state agency's deliberative processes, impressions, evaluations, opinions, recommendations, meeting minutes, research, work products, theories, or strategy, or that provide instruction, advice, or training to employees who do not have full collective bargaining and representation rights under these chapters. Nothing in this subdivision shall be construed to limit the disclosure duties of a state agency with respect to any other records relating to the activities governed by the employee relations acts referred to in this subdivision.

(q) Records of state agencies related to activities governed by Article 2.6 (commencing with Section 14081), Article 2.8 (commencing with Section 14087.5), and Article 2.91 (commencing with Section 14089) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, that reveal the special negotiator's deliberative processes, discussions, communications, or any other portion of the negotiations with providers of health care services, impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy, or that provide instruction, advice, or training to employees.

Except for the portion of a contract containing the rates of payment, contracts for inpatient services entered into pursuant to these articles, on or after April 1, 1984, shall be open to inspection one year after they are fully executed. If a contract for inpatient services that is entered into prior to April 1, 1984, is amended on or after April 1, 1984, the amendment, except for any portion containing the rates of payment, shall be open to inspection one year after it is fully executed. If the California Medical Assistance Commission enters into contracts with health care providers for other than inpatient hospital services, those contracts shall be open to inspection one year after they are fully executed.

Three years after a contract or amendment is open to inspection under this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

Notwithstanding any other provision of law, the entire contract or amendment shall be open to inspection by the Joint Legislative Audit Committee and the Legislative Analyst's Office. The committee and that office shall maintain the confidentiality of the contracts and amendments until the time a contract or amendment is fully open to inspection by the public.

(r) Records of Native American graves, cemeteries, and sacred places and records of Native American places, features, and objects described in Sections 5097.9 and 5097.993 of the Public Resources Code maintained by, or in the possession of, the Native American Heritage Commission, another state agency, or a local agency.

(s) A final accreditation report of the Joint Commission on Accreditation of Hospitals that has been transmitted to the State Department of Health Care Services pursuant to subdivision (b) of Section 1282 of the Health and Safety Code.

(t) Records of a local hospital district, formed pursuant to Division 23 (commencing with Section 32000) of the Health and Safety Code, or the records of a municipal hospital, formed pursuant to Article 7 (commencing with Section 37600) or Article 8 (commencing with Section 37650) of Chapter 5 of Part 2 of Division 3 of Title 4 of this code, that relate to any contract with an insurer or nonprofit hospital service plan for inpatient or outpatient services for alternative rates pursuant to Section 10133 of the Insurance Code. However, the record shall be open to inspection within one year after the contract is fully executed.

(u) (1) Information contained in applications for licenses to carry firearms issued pursuant to Section 12050 of the Penal Code by the sheriff of a county or the chief or other head of a municipal police department that indicates when or where the applicant is vulnerable to attack or that concerns the applicant's medical or psychological history or that of members of his or her family.

(2) The home address and telephone number of peace officers, judges, court commissioners, and magistrates that are set forth in applications for licenses to carry firearms issued pursuant to Section 12050 of the Penal

Code by the sheriff of a county or the chief or other head of a municipal police department.

(3) The home address and telephone number of peace officers, judges, court commissioners, and magistrates that are set forth in licenses to carry firearms issued pursuant to Section 12050 of the Penal Code by the sheriff of a county or the chief or other head of a municipal police department.

(v) (1) Records of the Managed Risk Medical Insurance Board related to activities governed by Part 6.3 (commencing with Section 12695), Part 6.5 (commencing with Section 12700), Part 6.6 (commencing with Section 12739.5), and Part 6.7 (commencing with Section 12739.70) of Division 2 of the Insurance Code, and that reveal any of the following:

(A) The deliberative processes, discussions, communications, or any other portion of the negotiations with entities contracting or seeking to contract with the board, entities with which the board is considering a contract, or entities with which the board is considering or enters into any other arrangement under which the board provides, receives, or arranges services or reimbursement.

(B) The impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.

(2) (A) Except for the portion of a contract that contains the rates of payment, contracts entered into pursuant to Part 6.3 (commencing with Section 12695), Part 6.5 (commencing with Section 12700), Part 6.6 (commencing with Section 12739.5), or Part 6.7 (commencing with Section 12739.70) of Division 2 of the Insurance Code, on or after July 1, 1991, shall be open to inspection one year after their effective dates.

(B) If a contract that is entered into prior to July 1, 1991, is amended on or after July 1, 1991, the amendment, except for any portion containing the rates of payment, shall be open to inspection one year after the effective date of the amendment.

(3) Three years after a contract or amendment is open to inspection pursuant to this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(4) Notwithstanding any other provision of law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The committee shall maintain the confidentiality of the contracts and amendments thereto, until the contracts or amendments to the contracts are open to inspection pursuant to paragraph (3).

(w) (1) Records of the Managed Risk Medical Insurance Board related to activities governed by Chapter 8 (commencing with Section 10700) of Part 2 of Division 2 of the Insurance Code, and that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with health plans, or the impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.

(2) Except for the portion of a contract that contains the rates of payment, contracts for health coverage entered into pursuant to Chapter 8 (commencing with Section 10700) of Part 2 of Division 2 of the Insurance Code, on or after January 1, 1993, shall be open to inspection one year after they have been fully executed.

(3) Notwithstanding any other provision of law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The committee shall maintain the confidentiality of the contracts and amendments thereto, until the contracts or amendments to the contracts are open to inspection pursuant to paragraph (2).

(x) Financial data contained in applications for registration, or registration renewal, as a service contractor filed with the Director of Consumer Affairs pursuant to Chapter 20 (commencing with Section 9800) of Division 3 of the Business and Professions Code, for the purpose of establishing the service contractor's net worth, or financial data regarding the funded accounts held in escrow for service contracts held in force in this state by a service contractor.

(y) (1) Records of the Managed Risk Medical Insurance Board related to activities governed by Part 6.2 (commencing with Section 12693) or Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code, and that reveal any of the following:

(A) The deliberative processes, discussions, communications, or any other portion of the negotiations with entities contracting or seeking to contract with the board, entities with which the board is considering a contract, or entities with which the board is considering or enters into any other arrangement under which the board provides, receives, or arranges services or reimbursement.

(B) The impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.

(2) (A) Except for the portion of a contract that contains the rates of payment, contracts entered into pursuant to Part 6.2 (commencing with Section 12693) or Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code, on or after January 1, 1998, shall be open to inspection one year after their effective dates.

(B) If a contract entered into pursuant to Part 6.2 (commencing with Section 12693) or Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code is amended, the amendment shall be open to inspection one year after the effective date of the amendment.

(3) Three years after a contract or amendment is open to inspection pursuant to this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(4) Notwithstanding any other provision of law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The committee shall maintain the confidentiality of the contracts and amendments thereto until the contract or amendments to a contract are open to inspection pursuant to paragraph (2) or (3).

(5) The exemption from disclosure provided pursuant to this subdivision for the contracts, deliberative processes, discussions, communications, negotiations, impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff shall also apply to the contracts, deliberative processes, discussions, communications, negotiations, impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of applicants pursuant to Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code.

(z) Records obtained pursuant to paragraph (2) of subdivision (c) of Section 2891.1 of the Public Utilities Code.

(aa) A document prepared by or for a state or local agency that assesses its vulnerability to terrorist attack or other criminal acts intended to disrupt the public agency's operations and that is for distribution or consideration in a closed session.

(ab) Critical infrastructure information, as defined in Section 131(3) of Title 6 of the United States Code, that is voluntarily submitted to the California Emergency Management Agency for use by that office, including the identity of the person who or entity that voluntarily submitted the information. As used in this subdivision, "voluntarily submitted" means submitted in the absence of the office exercising any legal authority to compel access to or submission of critical infrastructure information. This subdivision shall not affect the status of information in the possession of any other state or local governmental agency.

(ac) All information provided to the Secretary of State by a person for the purpose of registration in the Advance Health Care Directive Registry, except that those records shall be released at the request of a health care provider, a public guardian, or the registrant's legal representative.

(ad) The following records of the State Compensation Insurance Fund:

(1) Records related to claims pursuant to Chapter 1 (commencing with Section 3200) of Division 4 of the Labor Code, to the extent that confidential medical information or other individually identifiable information would be disclosed.

(2) Records related to the discussions, communications, or any other portion of the negotiations with entities contracting or seeking to contract with the fund, and any related deliberations.

(3) Records related to the impressions, opinions, recommendations, meeting minutes of meetings or sessions that are lawfully closed to the public, research, work product, theories, or strategy of the fund or its staff, on the development of rates, contracting strategy, underwriting, or competitive strategy pursuant to the powers granted to the fund in Chapter 4 (commencing with Section 11770) of Part 3 of Division 2 of the Insurance Code.

(4) Records obtained to provide workers' compensation insurance under Chapter 4 (commencing with Section 11770) of Part 3 of Division 2 of the Insurance Code, including, but not limited to, any medical claims information, policyholder information provided that nothing in this paragraph

shall be interpreted to prevent an insurance agent or broker from obtaining proprietary information or other information authorized by law to be obtained by the agent or broker, and information on rates, pricing, and claims handling received from brokers.

(5) (A) Records that are trade secrets pursuant to Section 6276.44, or Article 11 (commencing with Section 1060) of Chapter 4 of Division 8 of the Evidence Code, including without limitation, instructions, advice, or training provided by the State Compensation Insurance Fund to its board members, officers, and employees regarding the fund's special investigation unit, internal audit unit, and informational security, marketing, rating, pricing, underwriting, claims handling, audits, and collections.

(B) Notwithstanding subparagraph (A), the portions of records containing trade secrets shall be available for review by the Joint Legislative Audit Committee, the Bureau of State Audits, Division of Workers' Compensation, and the Department of Insurance to ensure compliance with applicable law.

(6) (A) Internal audits containing proprietary information and the following records that are related to an internal audit:

(i) Personal papers and correspondence of any person providing assistance to the fund when that person has requested in writing that his or her papers and correspondence be kept private and confidential. Those papers and correspondence shall become public records if the written request is withdrawn, or upon order of the fund.

(ii) Papers, correspondence, memoranda, or any substantive information pertaining to any audit not completed or an internal audit that contains proprietary information.

(B) Notwithstanding subparagraph (A), the portions of records containing proprietary information, or any information specified in subparagraph (A) shall be available for review by the Joint Legislative Audit Committee, the Bureau of State Audits, Division of Workers' Compensation, and the Department of Insurance to ensure compliance with applicable law.

(7) (A) Except as provided in subparagraph (C), contracts entered into pursuant to Chapter 4 (commencing with Section 11770) of Part 3 of Division 2 of the Insurance Code shall be open to inspection one year after the contract has been fully executed.

(B) If a contract entered into pursuant to Chapter 4 (commencing with Section 11770) of Part 3 of Division 2 of the Insurance Code is amended, the amendment shall be open to inspection one year after the amendment has been fully executed.

(C) Three years after a contract or amendment is open to inspection pursuant to this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(D) Notwithstanding any other provision of law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The committee shall maintain the confidentiality of the contracts and amendments thereto until the contract or amendments to a contract are open to inspection pursuant to this paragraph.

(E) Nothing in this paragraph is intended to apply to documents related to contracts with public entities that are not otherwise expressly confidential as to that public entity.

(F) For purposes of this paragraph, "fully executed" means the point in time when all of the necessary parties to the contract have signed the contract.

Nothing in this section prevents any agency from opening its records concerning the administration of the agency to public inspection, unless disclosure is otherwise prohibited by law.

Nothing in this section prevents any health facility from disclosing to a certified bargaining agent relevant financing information pursuant to Section 8 of the National Labor Relations Act (29 U.S.C. Sec. 158).

SEC. 2. Section 11126 of the Government Code is amended to read:

11126. (a) (1) Nothing in this article shall be construed to prevent a state body from holding closed sessions during a regular or special meeting to consider the appointment, employment, evaluation of performance, or dismissal of a public employee or to hear complaints or charges brought against that employee by another person or employee unless the employee requests a public hearing.

(2) As a condition to holding a closed session on the complaints or charges to consider disciplinary action or to consider dismissal, the employee shall be given written notice of his or her right to have a public hearing, rather than a closed session, and that notice shall be delivered to the employee personally or by mail at least 24 hours before the time for holding a regular or special meeting. If notice is not given, any disciplinary or other action taken against any employee at the closed session shall be null and void.

(3) The state body also may exclude from any public or closed session, during the examination of a witness, any or all other witnesses in the matter being investigated by the state body.

(4) Following the public hearing or closed session, the body may deliberate on the decision to be reached in a closed session.

(b) For the purposes of this section, "employee" does not include any person who is elected to, or appointed to a public office by, any state body. However, officers of the California State University who receive compensation for their services, other than per diem and ordinary and necessary expenses, shall, when engaged in that capacity, be considered employees. Furthermore, for purposes of this section, the term employee includes a person exempt from civil service pursuant to subdivision (e) of Section 4 of Article VII of the California Constitution.

(c) Nothing in this article shall be construed to do any of the following:

(1) Prevent state bodies that administer the licensing of persons engaging in businesses or professions from holding closed sessions to prepare, approve, grade, or administer examinations.

(2) Prevent an advisory body of a state body that administers the licensing of persons engaged in businesses or professions from conducting a closed session to discuss matters that the advisory body has found would constitute

an unwarranted invasion of the privacy of an individual licensee or applicant if discussed in an open meeting, provided the advisory body does not include a quorum of the members of the state body it advises. Those matters may include review of an applicant's qualifications for licensure and an inquiry specifically related to the state body's enforcement program concerning an individual licensee or applicant where the inquiry occurs prior to the filing of a civil, criminal, or administrative disciplinary action against the licensee or applicant by the state body.

(3) Prohibit a state body from holding a closed session to deliberate on a decision to be reached in a proceeding required to be conducted pursuant to Chapter 5 (commencing with Section 11500) or similar provisions of law.

(4) Grant a right to enter any correctional institution or the grounds of a correctional institution where that right is not otherwise granted by law, nor shall anything in this article be construed to prevent a state body from holding a closed session when considering and acting upon the determination of a term, parole, or release of any individual or other disposition of an individual case, or if public disclosure of the subjects under discussion or consideration is expressly prohibited by statute.

(5) Prevent any closed session to consider the conferring of honorary degrees, or gifts, donations, and bequests that the donor or proposed donor has requested in writing to be kept confidential.

(6) Prevent the Alcoholic Beverage Control Appeals Board from holding a closed session for the purpose of holding a deliberative conference as provided in Section 11125.

(7) (A) Prevent a state body from holding closed sessions with its negotiator prior to the purchase, sale, exchange, or lease of real property by or for the state body to give instructions to its negotiator regarding the price and terms of payment for the purchase, sale, exchange, or lease.

(B) However, prior to the closed session, the state body shall hold an open and public session in which it identifies the real property or real properties that the negotiations may concern and the person or persons with whom its negotiator may negotiate.

(C) For purposes of this paragraph, the negotiator may be a member of the state body.

(D) For purposes of this paragraph, "lease" includes renewal or renegotiation of a lease.

(E) Nothing in this paragraph shall preclude a state body from holding a closed session for discussions regarding eminent domain proceedings pursuant to subdivision (e).

(8) Prevent the California Postsecondary Education Commission from holding closed sessions to consider matters pertaining to the appointment or termination of the Director of the California Postsecondary Education Commission.

(9) Prevent the Council for Private Postsecondary and Vocational Education from holding closed sessions to consider matters pertaining to

the appointment or termination of the Executive Director of the Council for Private Postsecondary and Vocational Education.

(10) Prevent the Franchise Tax Board from holding closed sessions for the purpose of discussion of confidential tax returns or information the public disclosure of which is prohibited by law, or from considering matters pertaining to the appointment or removal of the Executive Officer of the Franchise Tax Board.

(11) Require the Franchise Tax Board to notice or disclose any confidential tax information considered in closed sessions, or documents executed in connection therewith, the public disclosure of which is prohibited pursuant to Article 2 (commencing with Section 19542) of Chapter 7 of Part 10.2 of Division 2 of the Revenue and Taxation Code.

(12) Prevent the Corrections Standards Authority from holding closed sessions when considering reports of crime conditions under Section 6027 of the Penal Code.

(13) Prevent the State Air Resources Board from holding closed sessions when considering the proprietary specifications and performance data of manufacturers.

(14) Prevent the State Board of Education or the Superintendent of Public Instruction, or any committee advising the board or the Superintendent, from holding closed sessions on those portions of its review of assessment instruments pursuant to Chapter 5 (commencing with Section 60600) of, or pursuant to Chapter 9 (commencing with Section 60850) of, Part 33 of Division 4 of Title 2 of the Education Code during which actual test content is reviewed and discussed. The purpose of this provision is to maintain the confidentiality of the assessments under review.

(15) Prevent the California Integrated Waste Management Board or its auxiliary committees from holding closed sessions for the purpose of discussing confidential tax returns, discussing trade secrets or confidential or proprietary information in its possession, or discussing other data, the public disclosure of which is prohibited by law.

(16) Prevent a state body that invests retirement, pension, or endowment funds from holding closed sessions when considering investment decisions. For purposes of consideration of shareholder voting on corporate stocks held by the state body, closed sessions for the purposes of voting may be held only with respect to election of corporate directors, election of independent auditors, and other financial issues that could have a material effect on the net income of the corporation. For the purpose of real property investment decisions that may be considered in a closed session pursuant to this paragraph, a state body shall also be exempt from the provisions of paragraph (7) relating to the identification of real properties prior to the closed session.

(17) Prevent a state body, or boards, commissions, administrative officers, or other representatives that may properly be designated by law or by a state body, from holding closed sessions with its representatives in discharging its responsibilities under Chapter 10 (commencing with Section 3500), Chapter 10.3 (commencing with Section 3512), Chapter 10.5 (commencing

with Section 3525), or Chapter 10.7 (commencing with Section 3540) of Division 4 of Title 1 as the sessions relate to salaries, salary schedules, or compensation paid in the form of fringe benefits. For the purposes enumerated in the preceding sentence, a state body may also meet with a state conciliator who has intervened in the proceedings.

(18) (A) Prevent a state body from holding closed sessions to consider matters posing a threat or potential threat of criminal or terrorist activity against the personnel, property, buildings, facilities, or equipment, including electronic data, owned, leased, or controlled by the state body, where disclosure of these considerations could compromise or impede the safety or security of the personnel, property, buildings, facilities, or equipment, including electronic data, owned, leased, or controlled by the state body.

(B) Notwithstanding any other provision of law, a state body, at any regular or special meeting, may meet in a closed session pursuant to subparagraph (A) upon a two-thirds vote of the members present at the meeting.

(C) After meeting in closed session pursuant to subparagraph (A), the state body shall reconvene in open session prior to adjournment and report that a closed session was held pursuant to subparagraph (A), the general nature of the matters considered, and whether any action was taken in closed session.

(D) After meeting in closed session pursuant to subparagraph (A), the state body shall submit to the Legislative Analyst written notification stating that it held this closed session, the general reason or reasons for the closed session, the general nature of the matters considered, and whether any action was taken in closed session. The Legislative Analyst shall retain for no less than four years any written notification received from a state body pursuant to this subparagraph.

(d) (1) Notwithstanding any other provision of law, any meeting of the Public Utilities Commission at which the rates of entities under the commission's jurisdiction are changed shall be open and public.

(2) Nothing in this article shall be construed to prevent the Public Utilities Commission from holding closed sessions to deliberate on the institution of proceedings, or disciplinary actions against any person or entity under the jurisdiction of the commission.

(e) (1) Nothing in this article shall be construed to prevent a state body, based on the advice of its legal counsel, from holding a closed session to confer with, or receive advice from, its legal counsel regarding pending litigation when discussion in open session concerning those matters would prejudice the position of the state body in the litigation.

(2) For purposes of this article, all expressions of the lawyer-client privilege other than those provided in this subdivision are hereby abrogated. This subdivision is the exclusive expression of the lawyer-client privilege for purposes of conducting closed session meetings pursuant to this article. For purposes of this subdivision, litigation shall be considered pending when any of the following circumstances exist:

(A) An adjudicatory proceeding before a court, an administrative body exercising its adjudicatory authority, a hearing officer, or an arbitrator, to which the state body is a party, has been initiated formally.

(B) (i) A point has been reached where, in the opinion of the state body on the advice of its legal counsel, based on existing facts and circumstances, there is a significant exposure to litigation against the state body.

(ii) Based on existing facts and circumstances, the state body is meeting only to decide whether a closed session is authorized pursuant to clause (i).

(C) (i) Based on existing facts and circumstances, the state body has decided to initiate or is deciding whether to initiate litigation.

(ii) The legal counsel of the state body shall prepare and submit to it a memorandum stating the specific reasons and legal authority for the closed session. If the closed session is pursuant to paragraph (1), the memorandum shall include the title of the litigation. If the closed session is pursuant to subparagraph (A) or (B), the memorandum shall include the existing facts and circumstances on which it is based. The legal counsel shall submit the memorandum to the state body prior to the closed session, if feasible, and in any case no later than one week after the closed session. The memorandum shall be exempt from disclosure pursuant to Section 6254.25.

(iii) For purposes of this subdivision, "litigation" includes any adjudicatory proceeding, including eminent domain, before a court, administrative body exercising its adjudicatory authority, hearing officer, or arbitrator.

(iv) Disclosure of a memorandum required under this subdivision shall not be deemed as a waiver of the lawyer-client privilege, as provided for under Article 3 (commencing with Section 950) of Chapter 4 of Division 8 of the Evidence Code.

(f) In addition to subdivisions (a), (b), and (c), nothing in this article shall be construed to do any of the following:

(1) Prevent a state body operating under a joint powers agreement for insurance pooling from holding a closed session to discuss a claim for the payment of tort liability or public liability losses incurred by the state body or any member agency under the joint powers agreement.

(2) Prevent the examining committee established by the State Board of Forestry and Fire Protection, pursuant to Section 763 of the Public Resources Code, from conducting a closed session to consider disciplinary action against an individual professional forester prior to the filing of an accusation against the forester pursuant to Section 11503.

(3) Prevent an administrative committee established by the California Board of Accountancy pursuant to Section 5020 of the Business and Professions Code from conducting a closed session to consider disciplinary action against an individual accountant prior to the filing of an accusation against the accountant pursuant to Section 11503. Nothing in this article shall be construed to prevent an examining committee established by the California Board of Accountancy pursuant to Section 5023 of the Business and Professions Code from conducting a closed hearing to interview an individual applicant or accountant regarding the applicant's qualifications.

(4) Prevent a state body, as defined in subdivision (b) of Section 11121, from conducting a closed session to consider any matter that properly could be considered in closed session by the state body whose authority it exercises.

(5) Prevent a state body, as defined in subdivision (d) of Section 11121, from conducting a closed session to consider any matter that properly could be considered in a closed session by the body defined as a state body pursuant to subdivision (a) or (b) of Section 11121.

(6) Prevent a state body, as defined in subdivision (c) of Section 11121, from conducting a closed session to consider any matter that properly could be considered in a closed session by the state body it advises.

(7) Prevent the State Board of Equalization from holding closed sessions for either of the following:

(A) When considering matters pertaining to the appointment or removal of the Executive Secretary of the State Board of Equalization.

(B) For the purpose of hearing confidential taxpayer appeals or data, the public disclosure of which is prohibited by law.

(8) Require the State Board of Equalization to disclose any action taken in closed session or documents executed in connection with that action, the public disclosure of which is prohibited by law pursuant to Sections 15619 and 15641 of this code and Sections 833, 7056, 8255, 9255, 11655, 30455, 32455, 38705, 38706, 43651, 45982, 46751, 50159, 55381, and 60609 of the Revenue and Taxation Code.

(9) Prevent the California Earthquake Prediction Evaluation Council, or other body appointed to advise the Director of the Office of Emergency Services or the Governor concerning matters relating to volcanic or earthquake predictions, from holding closed sessions when considering the evaluation of possible predictions.

(g) This article does not prevent either of the following:

(1) The Teachers' Retirement Board or the Board of Administration of the Public Employees' Retirement System from holding closed sessions when considering matters pertaining to the recruitment, appointment, employment, or removal of the chief executive officer or when considering matters pertaining to the recruitment or removal of the Chief Investment Officer of the State Teachers' Retirement System or the Public Employees' Retirement System.

(2) The Commission on Teacher Credentialing from holding closed sessions when considering matters relating to the recruitment, appointment, or removal of its executive director.

(h) This article does not prevent the Board of Administration of the Public Employees' Retirement System from holding closed sessions when considering matters relating to the development of rates and competitive strategy for plans offered pursuant to Chapter 15 (commencing with Section 21660) of Part 3 of Division 5 of Title 2.

(i) This article does not prevent the Managed Risk Medical Insurance Board from holding closed sessions when considering matters related to the development of rates and contracting strategy for entities contracting or seeking to contract with the board, entities with which the board is

considering a contract, or entities with which the board is considering or enters into any other arrangement under which the board provides, receives, or arranges services or reimbursement, pursuant to Part 6.2 (commencing with Section 12693), Part 6.3 (commencing with Section 12695), Part 6.4 (commencing with Section 12699.50), Part 6.5 (commencing with Section 12700), Part 6.6 (commencing with Section 12739.5), or Part 6.7 (commencing with Section 12739.70) of Division 2 of the Insurance Code.

(j) Nothing in this article shall be construed to prevent the board of the State Compensation Insurance Fund from holding closed sessions in the following:

(1) When considering matters related to claims pursuant to Chapter 1 (commencing with Section 3200) of Division 4 of the Labor Code, to the extent that confidential medical information or other individually identifiable information would be disclosed.

(2) To the extent that matters related to audits and investigations that have not been completed would be disclosed.

(3) To the extent that an internal audit containing proprietary information would be disclosed.

(4) To the extent that the session would address the development of rates, contracting strategy, underwriting, or competitive strategy, pursuant to the powers granted to the board in Chapter 4 (commencing with Section 11770) of Part 3 of Division 2 of the Insurance Code, when discussion in open session concerning those matters would prejudice the position of the State Compensation Insurance Fund.

(k) The State Compensation Insurance Fund shall comply with the procedures specified in Section 11125.4 of the Government Code with respect to any closed session or meeting authorized by subdivision (j), and in addition shall provide an opportunity for a member of the public to be heard on the issue of the appropriateness of closing the meeting or session.

SEC. 3. Part 6.7 (commencing with Section 12739.70) is added to Division 2 of the Insurance Code, to read:

PART 6.7. FEDERAL TEMPORARY HIGH RISK HEALTH INSURANCE FUND

12739.70. The definitions in Section 12739.50 shall apply to this part.

12739.71. There is hereby created in the State Treasury a special fund known as the Federal Temporary High Risk Health Insurance Fund that is, notwithstanding Section 13340 of the Government Code, continuously appropriated to the board for the purposes specified in Part 6.6 (commencing with Section 12739.5).

12739.72. The board shall authorize the expenditure of money in the fund to cover program expenses, including program expenses that exceed subscriber contributions.

12739.73. From amounts transferred to the fund, the board may expend sufficient funds to carry out the purposes of Part 6.6 (commencing with

Section 12739.5). The state shall not be liable beyond the assets of the fund for any obligations incurred, or liabilities sustained, in the operation of the program.

12739.74. Any moneys remaining in the fund at the end of any fiscal year may be carried forward to the next succeeding fiscal year.

12739.75. The board shall establish a reserve that is sufficient to prudently operate the program, unless the federal Department of Health and Human Services establishes other procedures to maintain a prudent reserve.

12739.76. This part shall remain in effect only until January 1, 2020, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2020, deletes or extends that date.

SEC. 4. The Legislature finds and declares that Sections 1 and 2 of this act, which amend Sections 6254 and 11126 of the Government Code, impose a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

In order to clarify existing law and to ensure that the Managed Risk Medical Insurance Board is not constrained in exercising its fiduciary powers and obligations to negotiate on behalf of the public as it implements federal health care reform pursuant to the federal Patient Protection and Affordable Care Act (Public Law 111-148), the limitations on the public's right of access imposed by Sections 1 and 2 of this act are necessary.

SEC. 5. This act shall become operative only if Senate Bill 227 of the 2009–10 Regular Session is also enacted and becomes operative.

SEC. 6. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to allow the state to apply for federal funding made available by Section 1101 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) at the earliest possible time, it is necessary that this act take effect immediately.

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